



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ELITE HEALTHCARE NORTH DALLAS
PO BOX 1210
FRISCO TX 75034

Carrier's Austin Representative Box

Box Number 53

Respondent Name

WAL MART ASSOCIATES INC

MFDR Received Date

OCTOBER 19, 2012

MFDR Tracking Number

M4-13-0504-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached dates of services 7/11/12, 7/12/12, 7/17/12, 7/18/12, 7/19/12, and 7/20/12 were not paid or not paid in full. **PER RULE 134.600, the INITIAL 6 POST OPERATIVE** physical therapy sessions do not require preauthorization. **I HAVE ATTACHED THE DICTATIONS FROM THE SURGEON SHOWING THAT THE PATIENT WAS IN A SPLINT FOLLOWING THE SURGERY, AND THEREFORE COULD NOT DO PHYSICAL THERAPY UNTIL RELEASED TO DO SO. THE PATIENT WAS RELEASED TO START PHYSICAL THERAPY ON 7/9/12. I HAVE ALSO ATTACHED A PICTURE OF THE SPLINT THAT WAS USED ON THIS PATIENT. AS YOU CAN SEE, IT IS IMPOSSIBLE TO DO PHYSICAL THERAPY WITH THIS SPLINT.** Therefore these claims should be paid in full to **prevent IRO (Independent Review Organization) and MDR (Medical Dispute Resolution).** I have attached all necessary documentation."

Amount in Dispute: \$2,494.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the attached documentation, which notes that the physical therapy rendered on 07/11/12 was not within the first two weeks immediately following surgery; therefore, required preauthorization in accordance with TDI Rule 134.600(C). No additional allowance is recommended. In regards to the office visit, an additional allowance in the amount of \$114.25 has been recommended. Please see the attached EOB's for review."

Response Submitted by: Hoffman Kelley, 5316 Hwy. 290 West, Suite 360, Austin, TX 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 11, 2012 through July 20, 2012	Office Visit Physical Therapy Services	\$2,494.21	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Payment denied/reduced for absence of precertification/authorization.
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
 - 5056 – Preauthorization not obtained.
 - 5081 – Reduction or denial of payment resulting after a reconsideration was completed.
 - 5148 – Final action has been taken on this bill. Per Rule 133.250(G), a health care provider shall not resubmit a request for reconsideration earlier than 35 days from the date the insurance carrier received the original request for reconsideration or after the insurance carrier has taken final action on the reconsideration request. Per Rule 133.250(H), if the health care provider is dissatisfied with the carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with DWC rule 133.305

Issues

1. Did the requestor received payment for CPT Code 99213 for date of service July 11, 2012?
2. Do the services in dispute require preauthorization?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the EOB, dated November 18, 2012, finds the respondent reimbursement the health care provider \$114.25 for the office visit billed on July 11, 2012. Therefore, this service will not be reviewed.
2. Per 28 Texas Administrative Code §134.600(p)(5)(C) states that preauthorization is required "except for the first six visits of physical or occupation therapy following the evaluation when such treatment is rendered within the first two weeks immediately following (ii) a surgical intervention previously preauthorized by the insurance carrier." Review of the documentation submitted by the requestor finds that the injured workers had surgery, arthrodesis of the left wrist with distal radius auto graft, on April 20, 2012. The physical therapy program was initiated July 11, 2012, approximately 12 weeks after surgery. Therefore, the physical therapy services required preauthorization.
3. Review of the submitted documentation finds that the requestor did not seek preauthorization for the services in dispute. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 3, 2013
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.